

The limits of government-run health care systems: the Swedish example*

by Valentin Petkantchin, associate researcher at the Institut économique Molinari

With the public accounts in a tailspin and the government trying to straighten things out, the French health care system will remain a key focus. There lurks a serious risk that government control could intensify.¹ Sweden provides a cautionary example in this regard. Facing a crisis in its public finances in the early 1990s, Sweden decided instead to provide more room for the private sector.

The Swedish case also shows that, once a health care system comes under heavy government control, it is left to the mercy of shifting political majorities. Back-and-forth reform and counter-reform have been a source of regulatory insecurity for health care professionals, ultimately penalising patients through widespread waiting lists.

COST CONTAINMENT IN THE 1980s

The Swedish health care system has historically been under heavy government control,² both in its financing and its operation. In the early 1980s, public financing accounted for 92.5% of total health care spending,³ through central government taxes and, to a greater extent, through local taxes.^{4,5}

Operation of the Swedish health care system was also almost entirely under government control. Unlike France, Germany or Switzerland, where private medical practice plays a major role, the provision of care in Sweden relied mainly on local public monopolies, i.e., public clinics and hospitals, financed and managed by local politicians. As a general rule, doctors and other health care professionals were civil servants, paid by county councils. About 80% of doctors worked in public hospitals.⁶

Patients had no freedom of choice. They were assigned to a primary health care centre and to a hospital, based on where they lived.



Noted for its generous social programs, the Swedish health care system was at the time one of the most expensive in the world.⁷ With the crisis of the 1970s and its impact on public finances, the county councils engaged in a policy of "cost containment" with regard to the overall budgets allocated to health care in the 1980s.

What was the result? Though there was slower growth in *per capita* public spending (+64% between 1980 and 1990, down from +226% between 1970 and 1980),⁸ this occurred at the cost of reduced access to care. As one specialist has noted, "during the latter half of the 1980s, increasingly long waiting lists for certain types of care became an important political issue."⁹

* The IEM thanks Fredrik Erixon, a Swedish economist and writer, Director of the European Centre for International Political Economy (ECIPE), for his comments in the preparation of this Note.

1. On this topic, see Valentin Petkantchin, "The ineffectiveness of health cost containment policies in France," Institut économique Molinari, March 2007, available at: <http://www.institutmolinari.org/the-ineffectiveness-of-health-cost,485.html>.

2. This is a system said to be of "Beveridgean" inspiration, like that in the United Kingdom. The difference is that, unlike the British system, the Swedish system is highly decentralised, enabling greater flexibility at the county level, in particular by delegating the provision of health care to the private sector to varying degrees. This let Stockholm county turn to the private sector, in contrast to other counties that kept their public systems.

3. Source: OECD Health Data, 2001.

4. Since 1982, county councils have been legally in charge of financing, organising and providing health care on their territories. Direct payments by patients in the form of user fees was the other source of financing in the 1980s, with private insurance playing a negligible role at the time.

5. See also Allan Krasnik and Bård Paulsen, "Reforming primary health care", in *Nordic health care systems*, Jon Magnussen *et al.*, eds., European Observatory on Health Systems and Policies Series, 2009, p. 244. Unlike routine care, handled by the counties, long-term care and certain types of psychiatric care became the responsibility of the municipalities, under reforms enacted in 1992 and 1995 respectively. The analysis contained in this economic note will be limited solely to routine care.

6. See A. Glenngård *et al.*, *Health Systems in Transition: Sweden*, European Observatory on Health Systems and Policies, 2005, p. 16 (late 1960s figure).

7. *Per capita* public spending on health care (based on purchasing power parity) was nearly the highest among OECD countries. Total health care spending accounted for 8.9% of GDP in 1980, putting Sweden just behind the United States, at 9.0%. Source: OECD, 2011.

8. Source: OECD, 2012; calculations by the author.

9. Åke Blomqvist, "International Health Care Models: Sweden," report to the Standing Senate Committee on Social Affairs, Science and Technology, Canada, 2001, p. 16. Available at: <http://www.parl.gc.ca/Content/SEN/Committee/371/soci/rep/volume3vr5-e.pdf>.

The Swedish experience in the 1980s shows the limits inherent to government-run systems: either the costs of public providers in monopoly situations run out of control (as happened before 1980), or politicians try to contain costs through bureaucratic means, in which case health care, although theoretically available to the entire populace, becomes unavailable in reality when patients need it.

THE 1990s EXPERIENCE AND THE STOCKHOLM MODEL: MORE ROOM FOR THE PRIVATE SECTOR

The breakdown of Swedish public finances gathered pace in the early 1990s. In the words of Goran Persson, a former finance minister and prime minister, "Sweden experienced its deepest recession since the 1930s. To cut a long story short, in three years public debt doubled, unemployment tripled, and public deficits increased tenfold."¹⁰

In response to these budget problems, and with the growing dissatisfaction of Swedes who had to put up with increasingly long waiting lists, reform consisted this time of allowing more room for the private sector and greater choice for patients.

Certain counties, Stockholm in particular, moved in this direction.

Though financed by taxes and supervised politically by county councils, the "Stockholm model" relies on bringing three new elements into managing the health care system.

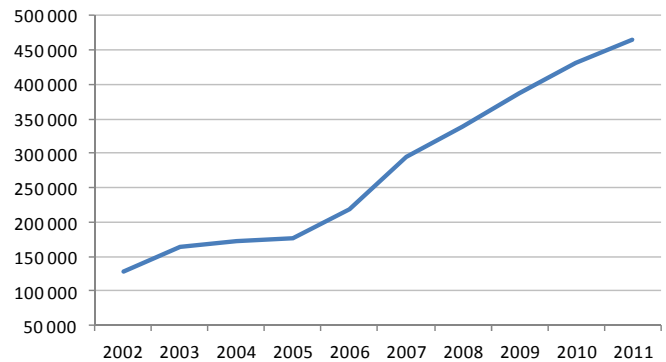
First, in the early 1990s, activity-based funding for health services was instituted (with financing based on diagnosis-related groups). The aim was for county councils to try to learn the cost of the various types of care and treatment they were paying for.

Second, the reform involved splitting the functions of purchaser and provider (the so-called "purchaser-provider split"). In 1994, about half of the county councils had introduced this type of division in some form or other.¹¹ In theory, this enabled the councils to get out of the day-to-day planning and management of hospitals or clinics. For example, St. Göran's Emergency Clinic was turned into a limited company in 1994 as a step toward its later privatisation.¹² Health care professionals (doctors, nurses, etc.) were encouraged to take over management of the clinics where they worked or to open new ones. In 1994, a law gave doctors the choice of where to practise, controlled until then by the county councils.¹³

Third, the county councils ("care purchasers") were able to put

Figure 1

Rise in the number of people with private health insurance, 2002-2011



Source: Swedish Insurance Federation, 2012.

care providers, whether public or private, into competition, to be applied both to primary and hospital care.

In the Stockholm area, these reforms led to productivity gains averaging about 16% between 1991 and 1993 and to a shortening of waiting lists (-30% in a single year) due to greater volumes of care. The drop in health care costs ranged from -10% (ambulatory transport) to -40% (laboratory analyses and radiography).¹⁴ St. Göran's Hospital became a reference for other hospitals in terms of sound management.¹⁵

Alongside this reform in the provision of health care, in 1992 the public authorities also allowed greater freedom of choice for patients. For example, patients who had not been treated within a maximum of three months were allowed to seek treatment at a clinic or hospital outside the region where they lived. In 1994, they also obtained the freedom to choose their family doctors.

But the election of new socialist majorities starting in the mid-1990s created challenges to the principles of the Stockholm model. It also showed the limits inherent to any tax-financed system under heavy government control.

THE PRIVATE SECTOR AND PATIENTS AT THE MERCY OF POLITICAL CHANGES

The Swedish case shows the extent to which a government-run system is dependent on the political process, which puts the private sector and health care professionals under extreme legal

10. Goran Persson, "The Swedish Experience in Reducing Budget Deficits and Debt," *Economic Review*, Federal Reserve Bank of Kansas City, issue Q I, p. 8.

11. See Pål Martinussen and Jon Magnussen, 2009, *op. cit.*, p. 24.

12. The reform process provided for the privatisation of St. Göran's Hospital in Stockholm in the late 1990s, clearly showing the logic of the reform undertaken ten years earlier.

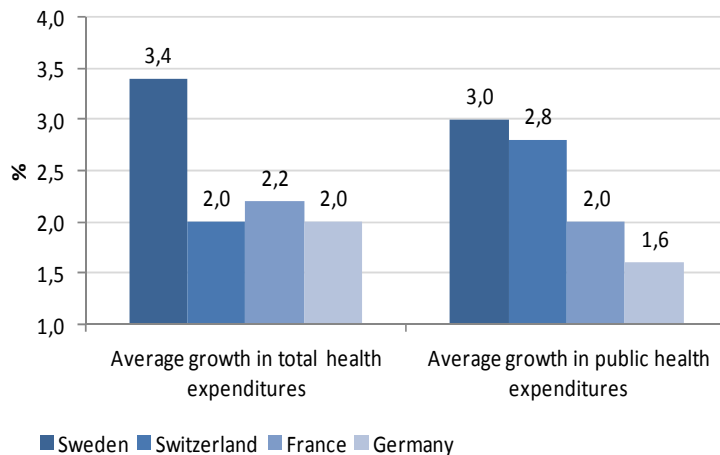
13. This was the Act on Freedom of Private Practices — A. Glengård *et al.*, 2005, *op. cit.*, p. 105. This law also allowed general practitioners to become independent entrepreneurs rather than salaried civil servants (see Pål Martinussen and Jon Magnussen, 2009, *op. cit.*, p. 27).

14. See Johan Hjertqvist, "The end of the beginning: The healthcare revolution in Stockholm, Part II," *Timbro Health Care Unit*, 2003, p. 8.

15. See Johan Hjertqvist, "The health care revolution in Stockholm," *Timbro Health Care Unit*, 2002, p. 22.

Figure 2

Average annual growth in *per capita* health spending, 2000-2009 (in %)



Source: OECD, 2012; figure and calculations by the author.

insecurity. This is why the impact and the broader adoption of reform based on the Stockholm model have remained limited.

For example, while private doctors were allowed to practise freely as of 1994, in 1995 this freedom was taken away from them. The initial idea of the Stockholm model was to put care providers into competition. But in the mid-1990s, the concept of competition gave way to that of "cooperation".¹⁶ The county councils kept a strong grip on the competitive process through arbitrary manipulation, thereby preventing patients from enjoying its full benefits. Several county councils introduced *de facto* restrictions and caps on the volumes of health care provided. Fees were also adjusted downwards on a regular basis, sometimes several times a year and retroactively, or even lowered to zero if a certain volume of care was exceeded.¹⁷

While St. Göran's Hospital was privatised and sold in 2000 by a non-socialist local majority, and while several other hospitals were turned into limited companies as a step toward privatisation, the socialist majority in the central government swept this process aside, prohibiting in 2001 any further privatisations. A law in 2006 required councils to manage at least one hospital on their territory on their own and prohibited them from delegating management of regional hospital establishments.¹⁸

Patients have also been big losers due to this political control over the health care system, and they have had to endure institutionalised waiting lists.

In the face of this access problem, politicians have tried to shorten waiting times by bureaucratic means. Political initiatives have proliferated, though without settling the problem. These initiatives were aimed at implementing "patients rights," especially with regard to maximum waiting times.

An official "guarantee" of a maximum three-month wait for certain surgical procedures was instituted in 1992 giving patients who did not receive treatment within that period the freedom, as mentioned here above, to seek care outside the county. This was replaced in 1996 by another provision aimed at guaranteeing maximum waiting times for an appointment with a nurse, a general practitioner and, if required, a medical specialist.¹⁹ However, despite the "guaranteed" maximum waiting times, waiting lists persisted. In 2003, for example, more than 60% of patients requiring hip replacements had to wait more than three months to be operated on.²⁰

A new initiative in 2005 imposes the so-called "0-7-90-90" rule (0 days for contact with the system, seven days to see a doctor, 90 days to see a specialist, and 90 more days following diagnosis to receive the treatment).²¹

Despite these initiatives, problems of health care access in the Swedish system have not gone away. This explains the growing popularity of private insurance in Sweden. The number of people taking out private insurance rose by a factor of 3.6 between 2002 and 2011 (see Figure 1 on page 2).

Private insurance has become a "safety valve" enabling some patients to cope with flaws in the public system. These access problems constitute substantial costs that are too easily ignored: stress, suffering, lost productivity, etc., for the entire population. As one study notes, private insurance indeed provides "quick access to a medical specialists, in case of need. Another advantage may be the possibility of moving to the front of the line to receive treatment (for elective surgery)."²²

Despite these deficiencies in health care access, the Swedish system is often vaunted on the grounds that it has achieved control of public spending and good health performance in

16. See A. Glenngård *et al.*, 2005, *op. cit.*, p. 50.

17. See Pål Martinussen and Jon Magnussen, 2009, *op. cit.*, p. 45.

18. See Unto Häkkinen and Pia Jonsson, "Harnessing diversity of provision," in *Nordic health care systems*, Jon Magnussen *et al.*, eds., European Observatory on Health Systems and Policies Series, 2009, p. 205. A non-socialist majority, elected to power in 2006, reversed these legislative provisions, showing again the dependence of the Swedish system on shifting political majorities.

19. See A. Glenngård *et al.*, 2005, *op. cit.*, pp. 76-77.

20. See the official report "Health care Status Report 2003," National Board of Health and Welfare, p. 13, available at: http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/10492/2004-131-4_summary.pdf.

21. This "guarantee" still remains in force.

22. A. Glenngård *et al.*, 2005, *op. cit.*, p. 33.

23. See, for example, the *Rapport d'information du Sénat d'Alain Vasselle et Bernard Cazeau sur la protection sociale et la réforme des retraites en Suède*, No. 377, July 2007, p. 27, in which it is noted that "Sweden appears favourably placed in international rankings."

terms of life expectancy,²³ for example. But is this really so?

Total health spending as a proportion of GDP does remain lower than in countries where health care systems rely traditionally on a dynamic private sector, such as France, Germany and Switzerland. However, without even taking account of the many costs associated with waiting lists, which are hard to quantify but very real nevertheless, it should be noted that per capita spending, for example, grew more quickly in the 2000s in Sweden than in those other three countries (see Figure 2 on page 3).

Though the Swedish population enjoys high life expectancy,²⁴ it has risen less quickly than in these comparison countries, whether at birth or at age 65 (see Figure 3).

In 1970, the Swedish population had similar or higher life expectancy at age 65 than populations in France or Switzerland. Forty years later, it had fallen behind.

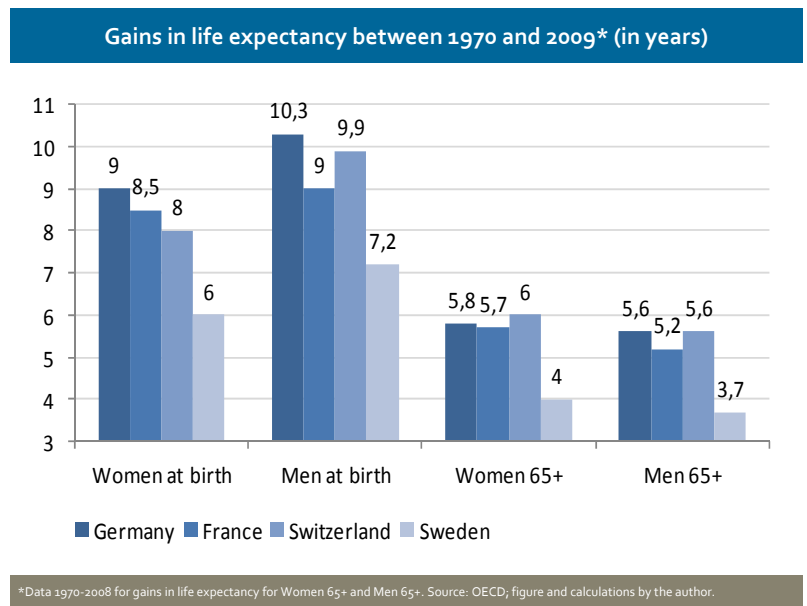
CONCLUSION

In the last 15 years, the many reforms to the French health care system have ended up producing growing bureaucratisation. This process could intensify due to government efforts aimed at reining in out-of-control public finances.

Unfortunately, as the Swedish experience shows, this sort of bureaucratisation may result in the appearance of chronic waiting lists. The Stockholm model shows that the solution is just the opposite. Faced with a similar situation in the early 1990s, Swedish public authorities decided to provide more room for the private sector in the government-run system and greater choice for patients. An emergency hospital in Stockholm was even privatised.

24. Life expectancy, especially at birth, depends on many factors other than the health care system alone (standard of living, level of economic development, etc.).

Figure 3



The Swedish example teaches us, meanwhile, that growing bureaucratisation of the health care system becomes all the more damaging because, once placed under government control, it is inevitably left to the mercy of politicians and shifting majorities. Even though an opening to the private sector provided for increased productivity and shorter waiting lists by ensuring improved access to care, the Stockholm model from the early 1990s was "anaesthetised" a few years later, with waiting lists again becoming a concern in the following decade.

In the face of deteriorating public finances, greater bureaucratisation aimed at "containing" health care costs is not a viable solution and can only be to health professionals' and patients' detriment. What the Swedish model teaches us is to avoid going further down the road of bureaucratisation and more government control.



Valentin Petkantchin

Mr. Petkantchin holds a doctorate in economics and a master's degree in communications media and economics training from the University of Aix-Marseille III in France. Between 1996 and 2003, he was a research fellow at the Centre for Economic Analysis and a lecturer in economics at the faculties of applied economics and law at the same university. He is the author of several scientific publications and research papers on various topics. He was research director at the Montreal Economic Institute from January 2004 to May 2006. He joined the Institut économique Molinari in June 2006.

The Institut économique Molinari (IEM) is an independent, non-profit research and educational organization. Its mission is to promote an economic approach to the study of public policy issues by offering innovative solutions that foster prosperity for all.

Reproduction is authorized on condition that the source is mentioned.

Director General: Cécile Philippe
Design: Gilles Guénette

www.institutmolinari.org